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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DOREEN LAVERNE SUTTON,** **a.k.a. DOREEN LAVERNE ERICKSON,** **a.k.a. DOREEN LAVERNE DECKER** **53620 Pine Canyon Road** **King City, CA 93930** **Registered Nurse License No. 468010** Respondent.	Case No. 2011-839 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 31, 1991, the Board issued Registered Nurse License Number 468010 to Doreen Laverne Sutton, also known as Doreen Laverne Erickson and Doreen Laverne Decker ("Respondent"). Respondent's registered nurse license expired on June 15, 2010.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

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license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
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> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for himself.

8. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to

procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

10. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

11. "Lortab", a combination drug containing hydrocodone bitartrate and acetaminophen, is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

12. "Norco", a combination drug containing hydrocodone bitartrate 10 mg and acetaminophen 325 mg, is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

13. "Dilaudid" , a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

14. "Percocet", a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N).

15. "Opiates" are Schedule I and II controlled substances as designated by Health and Safety Code sections 11054, subdivision (b), and 11055, subdivisions (b)(1) and (c), respectively.

16. "Benzodiazepines" are Schedule IV controlled substances as designated by Health and Safety Code section 11056, subdivision (d).

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MEMORIAL MEDICAL CENTER

FIRST CAUSE FOR DISCIPLINE

(Diversion of Controlled Substances)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that while on duty as a registered nurse in the Medical/Surgical Unit at Memorial Medical Center located in Modesto, California, Respondent obtained the controlled substances morphine, Lortab, Norco, Dilaudid, and Percocet by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: On and between March 1, 2008, and April 5, 2008, Respondent removed various quantities of morphine, Lortab, Norco, Dilaudid, and Percocet from the medical center's Pyxis MedStation (an automated drug dispensing machine requiring password sign-on for access; hereinafter "Pyxis"), for certain patients, but failed to chart the administration of the controlled substances on the patients' Medication Administration Records ("MAR"), failed to document the wastage of the controlled substances in the Pyxis, or falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries on the MARs to conceal her diversion of the controlled substances, as set forth in paragraph 18 below. Further, Respondent removed Lortab and Norco from the Pyxis before the next dose of the medication was to be given to the patient, as set forth in subparagraphs 18 (o) and (s) below.

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

18. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that on and between March 1, 2008, and April 5, 2008, while on duty as a registered nurse in the Medical/Surgical Unit at Memorial Medical Center located in Modesto, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances morphine, Lortab, Norco, Dilaudid, and Percocet, as follows:

Patient C:

a. On March 1, 2008, at 1905 hours, Respondent removed morphine 2 mg from the Pyxis for the patient, but failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 2 mg. Further, at 1730 hours and 2000 hours, other nurses documented on the patient's Pain Management flow sheet that the patient "denies pain".

Patient F:

b. On March 2, 2008, at 1008 hours, Respondent removed one tablet of Lortab 5 mg from the Pyxis for the patient when, in fact, Respondent discharged the patient from the unit at 1000 hours. Further, Respondent failed to chart the administration of the Lortab on the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the one tablet of Lortab 5 mg.

Patient G:

c. On March 6, 2008, at 0806 hours, Respondent removed two tablets of Norco 10 mg from the Pyxis for the patient, but failed to chart the administration of the Norco on the patient's MAR, document the wastage of the Norco in the Pyxis, and otherwise account for the disposition of the two tablets of Norco 10 mg. Further, other nurses documented on the MAR that the patient had been medicated with morphine throughout the shift.

d. On March 6, 2008, at 1231 hours, Respondent removed two tablets of Norco 10 mg from the Pyxis for the patient, but failed to chart the administration of the Norco on the patient's MAR, document the wastage of the Norco in the Pyxis, and otherwise account for the disposition of the two tablets of Norco 10 mg.

Patient L:

e. On March 13, 2008, at 0815 hours, Respondent removed one tablet of Lortab 7.5 mg from the Pyxis for the patient, but failed to chart the administration of the Lortab on the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the one tablet of Lortab 7.5 mg. Further, Respondent documented on the patient's Pain Management flow sheet at 0800 hours that the patient "denies pain."

Patient N:

f. On March 15, 2008, at 0808 hours, Respondent removed two tablets of Norco 10 mg from the Pyxis for the patient, but failed to chart the administration of the Norco on the patient's MAR, document the wastage of the Norco in the Pyxis, and otherwise account for the disposition of the two tablets of Norco 10 mg.

g. On March 15, 2008, at 1708 hours, Respondent removed two tablets of Norco 10 mg from the Pyxis for the patient, but charted on the nurses' notes that she administered two tablets of Norco 10 mg to the patient at *1646* hours. Further, Respondent failed to chart the administration of the Norco on the patient's MAR, document the wastage of the Norco in the Pyxis, and/or otherwise account for the disposition of the two tablets of Norco 10 mg.

h. On March 15, 2008, at 1413 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, documented on the patient's MAR that she wasted the Dilaudid at 1400 hours because the patient refused the medication, but failed to have another nurse witness the wastage.[1] Further, Respondent failed to document the wastage of the Dilaudid in the Pyxis or otherwise account for the disposition of the Dilaudid 2 mg.

Patient T:

i. On March 23, 2008, at 1358 hours, Respondent removed two tablets of Lortab 5 mg from the Pyxis for the patient, but failed to chart the administration of the Lortab on the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the two tablets of Lortab 5 mg.

j. On March 23, 2008, at 1630 hours, Respondent removed two tablets of Lortab 5 mg from the Pyxis for the patient, but failed to chart the administration of the Lortab on the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the two tablets of Lortab 5 mg.

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[1] The medical center's policy for "Wasting Medications", in effect at the time of the incident, states that if all or part of a controlled drug originally taken from the MedStation has been wasted, it will be documented at the MedStation by selecting the "Procedures" option from the main menu and then selecting the "Waste" option. Two nurses will be required to waste a controlled substance to document a witness for the wastage. The policy also states that all waste requires two licensed signatures or electronic signatures.

Patient V:

k. On March 26, 2008, at 0814 hours, Respondent removed two tablets of Lortab 7.5 mg from the Pyxis for the patient, but failed to chart the administration of the Lortab on the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the two tablets of Lortab 7.5 mg.

l. On March 26, 2008, at 1128 hours, Respondent removed two tablets of Lortab 7.5 mg from the Pyxis for the patient, but failed to chart the administration of the Lortab on the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the two tablets of Lortab 7.5 mg.

m. On March 26, 2008, at 1457 hours, Respondent removed two tablets of Lortab 7.5 mg from the Pyxis for the patient, but failed to chart the administration of the Lortab on the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the two tablets of Lortab 7.5 mg.

n. On March 26, 2008, at 1830 hours, Respondent removed two tablets of Lortab 7.5 mg from the Pyxis for the patient, but failed to chart the administration of the Lortab on the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the two tablets of Lortab 7.5 mg.

o. On March 26, 2008, between 0814 and 1830 hours, Respondent removed a total of eight tablets of Lortab 7.5 mg from the Pyxis for the patient, as set forth in subparagraphs (k) through (n) above, when, in fact, the physician's order called for the administration of one to two tablets of Lortab 7.5 mg every *4 to 6 hours* as needed.

Patient DD:

p. On March 30, 2008, at 1032 hours, Respondent removed two tablets of Norco 10 mg from the Pyxis for the patient, but failed to chart the administration of the Norco on the patient's MAR, document the wastage of the Norco in the Pyxis, and otherwise account for the disposition of the two tablets of Norco 10 mg.

q. On March 30, 2008, at 1409 hours, Respondent removed two tablets of Norco 10 mg from the Pyxis for the patient, but failed to chart the administration of the Norco on the patient's

MAR, document the wastage of the Norco in the Pyxis, and otherwise account for the disposition of the two tablets of Norco 10 mg.

r. On March 30, 2008, at 1754 hours, Respondent removed two tablets of Norco 10 mg from the Pyxis for the patient, but failed to chart the administration of the Norco on the patient's MAR, document the wastage of the Norco in the Pyxis, and otherwise account for the disposition of the two tablets of Norco 10 mg.

s. On March 30, 2008, between 1032 and 1754 hours, Respondent removed a total of six tablets of Norco 10 mg from the Pyxis for the patient, as set forth in subparagraphs (p) through (r) above, when, in fact, the physician's order called for the administration of one to two tablets of Norco 10 mg every *4 to 6 hours* as needed.

Patient FF:

t. On April 3, 2008, at 0848 hours, Respondent removed two Percocet tablets from the Pyxis for the patient, but failed to chart the administration of the Percocet on the patient's MAR, document the wastage of the Percocet in the Pyxis, and otherwise account for the disposition of the two tablets of Percocet. Further, Respondent documented on the patient's Adult Shift Assessment sheet that the patient denied having "pain issues" as of 0730 hours. In addition, Respondent noted on the Pain Management flow sheet at 0800 hours that the patient "denies pain".

u. On April 3, 2008, at 1315 hours, Respondent removed two Percocet tablets from the Pyxis for the patient, but failed to chart the administration of the Percocet on the patient's MAR, document the wastage of the Percocet in the Pyxis, and otherwise account for the disposition of the two tablets of Percocet. Further, Respondent documented on the patient's Pain Management flow sheet at 1200 hours that the patient "denies pain".

Patient JJ:

v. On April 5, 2008, at 0823 hours, Respondent removed one Norco 5 mg tablet from the Pyxis for the patient, but failed to chart the administration of the Norco on the patient's MAR, document the wastage of the Norco in the Pyxis, and otherwise account for the disposition of the one tablet of Norco.

w. On April 5, 2008, at 1307 hours, Respondent removed one Norco 5 mg tablet from the Pyxis for the patient, but failed to chart the administration of the Norco on the patient's MAR, document the wastage of the Norco in the Pyxis, and otherwise account for the disposition of the one tablet of Norco. Further, Respondent documented in the Pain Management flow sheet at 1200 hours that the patient was "in dialysis".

TWIN CITIES COMMUNITY HOSPITAL

THIRD CAUSE FOR DISCIPLINE

(Diversion and Self-Administration of Controlled Substances)

19. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivisions (a) and (b), in that while on duty as a registered nurse in the Medical/Surgical Unit at Twin Cities Community Hospital located in Templeton, California, Respondent did the following:

Diversion of Controlled Substances:

a. Respondent obtained the controlled substance Dilaudid by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: In and between March 2009 and June 2009, Respondent removed various quantities of Dilaudid from the hospital's Pyxis for certain patients, but failed to chart the administration of the Dilaudid on the patients' MARs and/or 24 HR PCA Flowsheets, failed to document the wastage of the Dilaudid in the Pyxis, or falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries on the MARs to conceal her diversion of the Dilaudid, as set forth in paragraph 20 below. Further, Respondent removed Dilaudid from the Pyxis before the next dose of the medication was to be given to the patient, as set forth in subparagraphs 20 (m) and (ee) below.

Self-Administration of Controlled Substances:

b. Respondent self-administered unknown quantities of benzodiazepines and opiates, controlled substances, without lawful authority therefor, as follows: On or about June 3, 2009,

D. M., the night shift charge nurse, was informed by registered nurse C. B. that Respondent had removed pain medication from the Pyxis for one of C. B.'s assigned patients. C. B. had not administered the medication to the patient because the patient was not in pain. C. B. checked the Pyxis and discovered that Respondent had removed the medication for her patient on two other occasions during that same shift. D. M. confronted Respondent regarding the incident and had Respondent taken down to the emergency room to submit a urine sample for drug testing. Respondent underwent a drug screen and tested positive for opiates and benzodiazepines.

FOURTH CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

20. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that on and between March 22, 2009, and June 3, 2009, while on duty as a registered nurse in the Medical/Surgical Unit at Twin Cities Community Hospital located in Templeton, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substance Dilaudid, as follows:

Patient A:

a. On March 22, 2009, at 0234 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

b. On March 22, 2009, at 2301 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

c. On April 1, 2009, at 1919 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR,

document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

d. On April 4, 2009, at 1912 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

e. On April 5, 2009, at 0429 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

f. On April 5, 2009, at 1900 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

g. On April 7, 2009, at 1959 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

h. On April 8, 2009, at 0022 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

i. On April 8, 2009, at 1857 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

j. On April 8, 2009, at 2304 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR,

document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

k. On April 9, 2009, at 0314 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

l. On April 9, 2009, at 0724 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

m. On and between April 8, 2009, at 1857 hours and April 9, 2009, at 0724 hours, a period of approximately 12 and a half hours, Respondent removed a total of 8 mg of Dilaudid for the patient, as set forth in subparagraphs (i) through (l) above, when, in fact, the physician's order called for the administration of 2 mg of Dilaudid every *6 hours* as needed.

n. On April 5, 2009, at 2119 hours, Respondent removed Dilaudid PCA 20 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid PCA 20 mg.

Patient B

o. On June 2, 2009, between 2220 and 2221 hours, Respondent removed a total of 4 mg of Dilaudid from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 4 mg.

p. On June 3, 2009, at 0550 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 4 mg.

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Patient C:

q. On May 14, 2009, at 0632 hours, Respondent removed Dilaudid PCA 20 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's 24 HR PCA Flowsheet, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid PCA 20 mg.

r. On May 27, 2009, at 0528 hours, Respondent removed Dilaudid PCA 20 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's 24 HR PCA Flowsheet, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid PCA 20 mg.

s. On May 28, 2009, at 0537 hours, Respondent removed Dilaudid PCA 20 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's 24 HR PCA Flowsheet, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid PCA 20 mg.

Patient D:

t. On May 5, 2009, at 2117 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

u. On May 6, 2009, at 0352 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

v. On May 6, 2009, at 2027 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

w. On May 6, 2009, at 2309 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR,

document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

x. On May 7, 2009, at 0140 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

y. On May 7, 2009, at 0520 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient E:

z. On May 13, 2009, at 2105 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient F:

aa. On June 3, 2009, at 0016 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

bb. On June 3, 2009, at 0325 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient G:

cc. On May 19, 2009, at 1959 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR,

document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

dd. On May 19, 2009, at 2146 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

ee. On May 19, 2009, between 1959 and 2146 hours, Respondent removed a total of 4 mg of Dilaudid for the patient, as set forth in subparagraphs (cc) and (dd) above, when, in fact, the physician's order called for the administration of 1 to 2 mg of Dilaudid every *3 hours* as needed.

ff. On May 20, 2009, at 0154 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

gg. On May 20, 2009, at 0541 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

hh. On May 20, 2009, at 2136 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient H:

ii. On May 30, 2009, at 2147 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

jj. On May 31, 2009, at 0119 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

kk. On May 31, 2009, at 0637 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

ll. On June 1, 2009, at 0015 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient I:

mm. On May 30, 2009, at 2048 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg. Further, the patient was pronounced dead on May 30, 2009, at 2120 hours.

Patient J:

nn. On May 30, 2009, at 1916 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

oo. On May 30, 2009, at 2252 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

pp. On May 31, 2009, at 0326 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR,

document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

qq. On June 1, 2009, at 0550 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

rr. On June 2, 2009, at 1920 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient K:

ss. On May 30, 2009, at 2017 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

tt. On May 30, 2009, at 2354 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

uu. On May 31, 2009, at 0502 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

vv. On June 1, 2009, at 0041 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 468010, issued to Doreen Laverne Sutton, also known as Doreen Laverne Erickson and Doreen Laverne Decker;

2. Ordering Doreen Laverne Sutton, also known as Doreen Laverne Erickson and Doreen Laverne Decker, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/12/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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